REGIONAL & COMMUNITY ICFs/MR PROTOCOL FOR OBTAINING ICF/MR LEVEL OF CARE

Effective August 2003

In order for a DDSN eligible consumer to claim Medicaid reimbursement for Intermediate Care Facility for the Mentally Retarded (ICF/MR) services, Title XIX of the Social Security Act requires that a physician make a Level of Care (LOC) determination. This requirement is stipulated within 42 Code of Federal Regulation, Chapter IV; Subpart F; §456.350 through § 456.381.

The purpose of the LOC determination is to assess the consumer's needs against criteria approved by the SC Department of Health & Human Services. The LOC determination should be made using the sequential steps below:

Definitions:

- *"Provider" = Regional or community based ICF/MR*
- *"Designee" = A professional with a Bachelors degree in human services from an accredited college or university as identified by the Provider's policy, or nurse.*
- *"Initial Level of Care" = Conducted by DDSN Consumer Assessment Team (CAT) for consumers who are being admitted to an ICF/MR for the first time.*
- *"Annual" = Conducted by the Provider within 365 calendar days.*

A. INITIAL LEVEL OF CARE:

The Provider's Director of Nursing (or designee) is responsible for insuring that the initial ICF/MR LOC determination is obtained at the time of the consumer's admission.

STEP # 1

The Provider's Director of Nursing (or designee) is responsible for completing the Request for ICF/MR Level of Care (Attachment A). The name, address and telephone number of the Director of Nursing (or designee) must be included so that completed evaluations can be returned.

STEP # 2

The Provider's Director of Nursing (or designee) is responsible for obtaining copies (not originals) of the following support documents, to be included with the Request for ICF/MR Level of Care (Attachment A):

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores (does not have to be current within three (3) years). Every effort should be made to locate actual evaluation report(s) vs. referencing results noted on another document. If report(s) cannot be located, the following other sources may be used:

- DDSN Eligibility Letter;
- DDSN STS Eligibility Menu
- Any other document which includes test used, scores, and date

If the consumer does not have mental retardation and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be e.g. a report from the DDSN Autism Division (ex. Related Disability).

2. Current Single Plan, or Individualized Family Service Plan.

3. Any/all other current (within one year) information pertaining to:

   - Daily living and other adaptive functioning
   - Behavioral/emotional functioning; and/or
   - Medical and related health needs

STEP # 3

The Provider's Director of Nursing (or designee) is responsible making the ICF/MR LOC request by mailing the Request for ICF/MR Level of Care (Attachment A), and copies of support documents, to:

DDSN Midlands Field Office
Attention: Director, Consumer Assessment Team
8301 Farrow Road
Columbia, SC 29203-3294

Support documents should be organized, stapled, and placed in a manila folder.

STEP # 4

A physician, who is a member of the DDSN Consumer Assessment Team, is responsible for making the initial ICF/MR LOC determination. DDSN Consumer Assessment Team should document its findings on the Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and Level Care Evaluation Staffing Report (Attachment D). These forms are provided by the CAT.

The DDSN Consumer Assessment Team Director is responsible for insuring that the ICF/MR LOC determination is made within ten (10) business days (assuming proper documentation is received), after the receipt of the Request for ICF/MR LOC packet from the Provider.

STEP # 5

When the Provider's Director of Nursing (or designee) receives an **approved** ICF/MR LOC determination, the Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and Level of Care Evaluation Staffing Report

(Attachment D) should be forwarded to the consumer's QMRP to be filed in the consumer's record.

If, however, the Consumer Assessment Team finds that the consumer **does not meet** ICF/MR Level of Care, the Request for ICF/MR Level of Care (Attachment A), support documents, Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and Level of Care Evaluation Staffing Report (Attachment D), will be forwarded by the DDSN Consumer Assessment Team to the DDSN Director of Adult Supports for review.

Once a final decision is reached, the DDSN Director of Adult Supports will return the documents to the DDSN Consumer Assessment Team Director for review, who will in-turn, notify the Provider's Director of Nursing (or designee). All documents will be returned to the Provider's Director of Nursing (or designee) to be filed in the consumer's record. Only in cases where the final LOC determination is not met, should the Provider's Director of Nursing (or designee) notify the consumer of the adverse decision and their right to appeal.

NOTE: Initial LOC may be completed prior to admission, but will expire if the consumer is not admitted to the ICF/MR within 30 calendar days of the LOC period (See Section C).

B. ANNUAL LEVEL OF CARE:

The Provider's Director of Nursing (or designee) is responsible for insuring that the annual ICF/MR LOC determination is made within 365 calendar days of the initial LOC determination, and within 365 calendar days thereafter.

STEP # 1

The Provider's Director of Nursing (or designee), in conjunction with the consumer's QMRP, is responsible for making sure the following support documents are used as basis for the ICF/MR LOC determination:

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores (does not have to be current within three (3) years). Every effort should be made to locate actual evaluation report(s) vs. referencing results noted on another document. If report(s) cannot be located, the following other sources may be used:

    - DDSN Eligibility Letter;
    - DDSN STS Eligibility Menu
    - Any other document which includes test used, scores, and date

    If the consumer does not have mental retardation and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be e.g. a report from the DDSN Autism Division (ex. Related Disability).

2. Current Single Plan, or Individualized Family Service Plan.

3. Any/all other current (within one year) information pertaining to:

    - Daily living and other adaptive functioning
    - Behavioral/emotional functioning; and/or
    - Medical and related health needs

STEP # 2

The Provider's Director of Nursing (or designee), is responsible for completing the Level of Care Certification Letter (Attachment B), and Level of Care Determination for ICF/MR (Attachment C), based on support documents noted in Step #1, of this section.

STEP # 3

The Provider's Director of Nursing (or designee) is responsible for presenting the completed Level of Care Certification Letter (Attachment B), and the completed Level of Care Determination for ICF/MR (Attachment C), to the consumer's primary care physician (or physician assistant or nurse practitioner, under the supervision of a physician), who is responsible for making the annual ICF/MR LOC determination, and documenting his/her findings on the Level of Care Evaluation Staffing Report (Attachment D).

STEP # 4

When the Provider's Director of Nursing (or designee) receives an **approved** ICF/MR LOC determination, the Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and the Level of Care Evaluation Staffing Report (Attachment D) should be forwarded to the consumer's QMRP to be filed in the consumer's record.

If, however, the ICF/MR LOC determination is **not approved**, the Consumer Assessment Team must review the LOC. The Provider's Director of Nursing (or designee) must immediately forward a Request for ICF/MR Level of Care (Attachment A), with copies (not originals) of the support documents, the Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and Level of Care Evaluation Staffing Report (Attachment D) to:

DDSN Midlands Field Office
Attention: Director, Consumer Assessment Team
8301 Farrow Road
Columbia, SC 29203-3294

If the DDSN Consumer Assessment Team reverses the decision, the DDSN Consumer Assessment Team will complete a new Level of Care Certification Letter (Attachment B), Level of Care Determination for ICF/MR (Attachment C), and Level of Care Evaluation Staffing Report (Attachment D) and forward these documents back to the Provider's Director of Nursing (or designee) to be filed in the consumer's record.
If, however, the DDSN Consumer Assessment Team concurs with the decision, the Level of Care Certification Letters (Attachment B), Level of Care Determination for ICF/MR

(Attachment C), Level of Evaluation Staffing Report (Attachment D), and support documents will be forwarded to DDSN Director of Adult Supports for further review.

Once a final decision is reached, the DDSN Director of Adult Supports will return the documents to the DDSN Consumer Assessment Team Director for review, who will in-turn, notify the Provider's Director of Nursing (or designee). All documents will be returned to the Provider's Director of Nursing (or designee) to be filed in the consumer's record. Only in cases where the final LOC determination is not met, should the Provider's Director of Nursing (or designee) notify the consumer of the adverse decision and their right to appeal.

C. DISCHARGE / RE-ADMISSION & EXPIRED LOC

When a consumer is discharged to a non-ICF/MR setting (e.g., home, Community Training Home, Community Residential Care Facility, Supervised Living Program, hospital, nursing home) or discharged due to exceeding the leave or nights away requirements **and returns** to the ICF/MR, the Provider is responsible for conducting the re-admission LOC using the same protocol listed in Section B above.

When a consumer is not admitted to the ICF/MR within 30 days after the initial CAT LOC determination, the Provider is responsible for contacting the CAT so that the LOC can be updated when all issues are resolved which delayed the admission. The provider should first verify that the consumer's condition has not changed. The provider may then request an update from CAT by phoning/faxing the cover sheet (Attachment A), the initial LOC Determination form (Attachment C), and the original Certification letter (Attachment B). Once the update is completed by CAT, the provider will receive a new Certification letter and the updated Level of Care determination form.

If the consumer's condition has changed, a phone/fax update cannot be done; instead, a complete LOC packet should be sent following steps in Section A.

D. EXCEPTIONS:

Specifically excluded from ICF/MR LOC requirements are:

- Consumers who are not eligible for Medicaid.
- Consumers decertified from the ICF/MR Medicaid program.
- Consumers discharged/transferred between ICFs/MR, when the ICF/MR LOC determination has not expired.
- When it is reasonably anticipated that the stay of the consumer **will not** exceed thirty calendar days (ex. respite or short-term admission).

PROCESS FOR APPEALING ICF/MR LOC DECISIONS

As a Medicaid applicant/recipient you have the right at any time to request a fair hearing from the SC Department of Health and Human Services regarding a decision affecting Medicaid eligibility or services. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of written notification for any action adversely affecting your Medicaid coverage.

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

You may be eligible to receive continued Medicaid benefits pending a hearing decision. If you are interested in continued benefits you must contact your case manager within 10 calendar days of the effective date of the action. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received during the appeals process.

Please attach a copy of the written notification with your appeal request. In your request for a fair hearing, you must state with specificity, which issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of written notification, the decision will be final and binding. A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of written notification. You will be advised in writing by the Division of Appeals and Hearings as to the status of your appeal.

GUIDANCE for COMPLETING ICF/MR LEVEL of CARE

General Guidance:

1. LOC is not a simple checklist. It is an assessment process that involves gathering and reviewing appropriate reports, drawing logical conclusions that can be easily tracked, documenting information sources, and completing forms accurately.

2. Every consumer who is eligible for services will not meet LOC. This can only occur by the assessment process in #1 above.

3. Do not complete LOC with current services in mind or based on personal familiarity. This should be an objective assessment based on supporting documentation.

4. It is inappropriate to copy the last LOC. Consumers change for better or worse, and the current LOC should be based on current information.

5. Answer every question YES or NO on the LOC Determination form, even though only one YES is required in each of the three sections to meet LOC.

6. Always document the source(s) of information used and the date of the report on the line provided below each section. The use of multiple documents is not only permitted but also encouraged. These reports and their corresponding dates can be written on the line provided, as well as extra space beneath the line.

7. Be sure the type of report used to answer questions is an appropriate resource. For example, do not reference a Behavioral Consultation to document MR, thinking it is a psychological report. If the consumer has a Related Disability, a psychological report may not be an appropriate reference.

8. Be sure all appropriate blanks on the LOC Determination form and the Certification Letter are completed.

9. Any item checked YES must be addressed in the single plan. For example, how is the presence of a severe behavior problem identified as a need in the single plan, and what services are planned to address it?

    - On the Level of Care Certification Letter (Attachment B), the "Effective Date" should be the same as the "Approved For ICF/MR LOC Signature/Title Date" on the Level of Care Determination for ICF/MR (Attachment C), and the "Evaluation Date" on the Level of Care Evaluation Staffing Report (Attachment D).

10. On the Level of Care Evaluation Staffing Report (Attachment D), ignore the reference to "Office of Consumer Assessment" and "Team Member Signatures".

Specific Guidance for Completing the Level of Care Determination:

SECTION 1—This person has:

- At least one item much be checked YES. A consumer meets the basic qualification for this section by having either Mental Retardation (MR) or a Related Disability (RD).
- High Risk Infants/At Risk Children will not meet this LOC.
- Consumers with Head Injury, Spinal Cord Injury or Similar Disability will usually not meet this LOC, however each person should be assessed individually for this requirement.

MENTAL RETARDATION

1. Whenever possible a direct source (e.g. psychological evaluation with formal test scores, DDSN eligibility document) should be referenced versus an anecdotal/indirect source such as a social history, physician's report, or STS report.

2. Although there is no requirement for how current a psychological report must be for purposes of LOC, it is expected that any report used must be a valid assessment. Thus, an older report may be acceptable to document MR if it is still believed to be accurate. If, however, the psychological report is no longer considered valid, based on more current information about the consumer, the diagnosis of MR should be questioned. Consultation with Consumer Assessment Team (CAT) may be needed in such cases.

3. If all attempts to locate a direct source document have been exhausted, but an indirect source does reference a psychological evaluation, with date and test scores, this may be used. An explanatory note should be written on the form to this effect.

RELATED DISABILITY

1. The DDSN interpretation of RD has changed over the years from being loosely defined (e.g. anyone with cerebral palsy with or without MR) to the present, well defined criteria (no MR but adaptive behavior in the severe range or significant motor problems in three life skills areas.) Only CAT can make this determination.

2. Consult Eligibility documents, the STS, or CAT to ascertain whether the consumer is eligible for services under MR or RD. Whenever possible a direct source used by CAT to diagnose a Related Disability should be referenced for LOC. Check the appropriate box accordingly and document the source and date.

SECTION 2—This person requires supervision due to:

- At least one item must be checked YES.
- A consumer requires supervision or monitorship in carrying out essential life skills in areas such as personal care, health, and adaptive behavior.
- Most supporting documentation for this section will come from the Single Plan or other program plans that identify goals and objectives for supports received, IEPs, therapy reports, Social Update, Medical and/or Behavior reports, if applicable.

- **Outdated information (i.e. no longer accurate or relevant) should not be used to answer questions in this section.** However relevant historical information that may influence current supervision needs should be considered and may be noted.

IMPAIRED JUDGMENT

- This might be expected in the presence of a thought/mood disorder, other psychiatric, or severe behavior problems.

- This almost always applies if a consumer is treated with psychotropic medication. Exceptions might include treatment for an episodic/temporary condition or mild depression.

- This might also include elopement, sexual acting out, and demonstrated limited awareness of personal health and safety matters.

- Impaired judgment may or may not occur in conjunction with LIMITED CAPABILITIES (see below).

LIMITED CAPABILITIES

- This includes deficits with basic self-care and/or management in the course of activities of daily living. A consumer who is able, but does not carry out such activities without reminders or prompts would usually be considered to have impaired judgment vs. limited capabilities

- This is closely correlated with a consumer's level of disability, meaning that a consumer with severe or profound MR or other disability will almost always demonstrate limited capabilities. Careful consideration should be given to consumers with less severe disabilities, who may be mostly independent. Goals and objectives should be reviewed to assist in making the appropriate judgment about whether this constitutes limited capabilities.

BEHAVIOR

- Professional judgment must be used to determine the type, extent, and impact of the problem.

- Caution should be used in interpreting terms such as "stubborn" or "noncompliant".

- If either ABUSIVE or ASSAULTIVE are checked (see below), Behavior should logically be checked YES as well.

ABUSIVE

- This usually applies to verbal abuse or self-abuse.

ASSAULTIVE

- This usually applies to physical aggression and/or property destruction.

DRUG EFFECTS/MEDICAL MONITORSHIP

- Professional judgment must be used to determine the type and impact of drug and medical concerns and the extent of monitorship required.

- Conditions requiring seizure, diabetic, most psychotropic, and other significant medication and treatment should be checked YES.

- Benign conditions and certain routine medications may require little or no monitorship or may be easily managed by the consumer or family.

SECTION 3—This person needs services to:

- At least one item must be checked YES.
- A consumer requires support services to encourage skill development toward independence and/or to prevent regression.

1. The same documents used to support questions in Section 2 can often be used to answer questions in this section, however additional documents may also be reviewed.

2. Since records may not explicitly state the need for acquisition of new skills or prevention of regression, some professional judgment may be needed to interpret records in order to answer these questions. This is accomplished by considering the totality of a person's status including the type and extent of disability, living environment, supervision needs, history, and goals and objectives indicated in the single plan or other treatment plans.

APPROVAL FOR ICF/MR LOC

- In order to check YES, there must be at least one YES checked in Sections 1, 2, and 3. Otherwise, this LOC cannot be met and NO should be checked.

INITIAL

1. This refers to the first LOC completed by DDSN/CAT.

2. If admission does not occur within 30 days of the effective date on the Certification Letter, the LOC is considered expired. CAT must be consulted.

ANNUAL RECERTIFICATION

1. This usually refers to the LOC completed within 365 calendar days of the initial LOC determination, and within 365 calendar days thereafter. This is completed by the Provider's Director of Nursing (or designee) yearly for consumers.

SIGNATURE/DATE

1. This must be done by the person completing the LOC.

Specific Guidance for Completing the Level of Care Certification Letter (Attachment B):

- This is the official certification or notification that LOC was or was not met. Failure to properly complete this letter prevents further action, even if the LOC Determination was completed properly.
- The first set of parentheses ( ) should be checked if this LOC is not met.
- The second and third set of parentheses must be checked when this LOC is met.

EFFECTIVE DATE

- This is usually the same date the LOC determination was completed, especially for INITIAL LOC.

EXPIRATION DATE

- This is usually one year from the EFFECTIVE DATE, unless the situation warrants more frequent LOC. For example, if the EFFECTIVE DATE was 1/6/01, the EXPIRATION DATE would be 1/5/02.

ASSESSOR

- This refers to the person completing the LOC.

DATE OF ASSESSMENT

- This refers to the date the LOC determination was completed.